MEDI-CAL UPDATE Part 2
Billing and Policy
www.medi-cal.ca.gov

Medical Services • Obstetrics

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Contents

Billing Tips for Medi-Cal Universal Claim Form Transition Period

Beginning April 23, 2007 through June 24, 2007, Medi-Cal will accept both versions of the professional claim form, either the *HCFA 1500* or the *CMS-1500*. During this period, providers are encouraged to migrate their business processes away from the *HCFA 1500*, depleting their form stock, in preparation for exclusive use of the *CMS-1500*.

Providers may choose to fully transition to the new *CMS-1500* claim form at any time during this two-month window before the use of the *CMS-1500* is mandatory. Beginning June 25, 2007, Medi-Cal will only accept the *CMS-1500*.

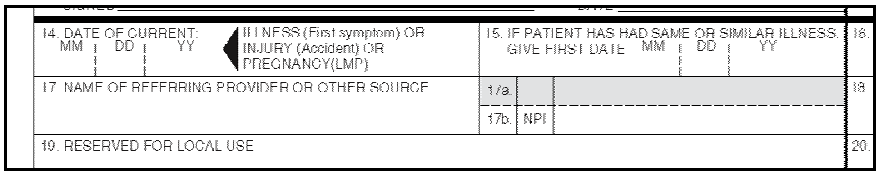
Separate billing instructions apply, as Medi-Cal is announcing a National Provider Identifier (NPI) dual-use period that starts during the claim form transition period. (For more information on the NPI implementation date, refer to the Medi-Cal Web site [www.medi-cal.ca.gov] and future *Medi-Cal Updates*.)

Providers billing on the new *CMS-1500* claim form must continue to use their Medi-Cal provider number until instructed otherwise. Beginning May 23, 2007, the NPI, if available, should be reported along with the Medi-Cal provider number, but is not necessary for proper adjudication.

For providers who choose to use the new claim form during the transition period, below are instructions on how to fill out the new form during the April 23 to June 24 time frame.

Providers may also continue to use the *HCFA 1500* claim form during the transition period and bill as they do currently. To clarify, providers using the *HCFA 1500* must use their Medi-Cal provider number. Only the new *CMS-1500* supports provision of both identifiers.

Box 17



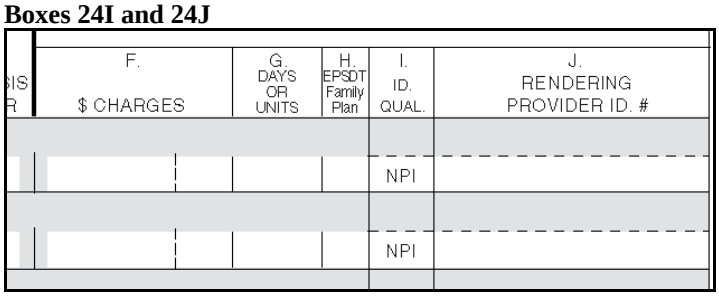
If a referring provider is necessary, providers should list the referring provider's name in Box 17 and enter the referring provider's Medi-Cal provider number or state license number in Box 17A. Providers can enter the referring provider's NPI in Box 17B.

When the referring provider is a Non-physician Medical Practitioner (NMP) working under the supervision of a physician, enter the name of the NMP in Box 17. Beginning April 23, 2007 and until instructed otherwise, enter the NMP's Medi-Cal provider number or state license number in Box 17A. Providers will be instructed at a later date when they can enter the referring provider's NPI in Box 17B.

Please see **Billing Tips**, *page 2*

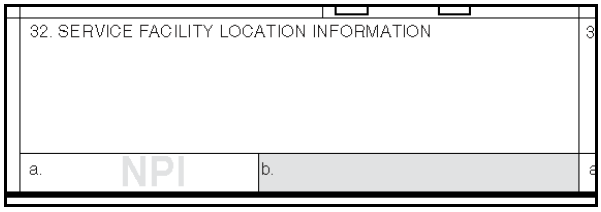
Billing Tips *(continued)*

Boxes 24I and 24J



Box 24I is not required by Medi-Cal. Box 24J is only necessary if the individual rendering provider number is different from the billing provider number. If the provider numbers are different, then enter the rendering provider's Medi-Cal number in the shaded area of Box 24J. Do not enter a physician license number in Box 24J. Providers can enter the rendering provider's NPI in the unshaded area of Box 24J.

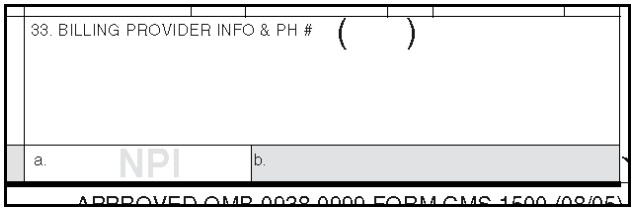
Box 32



In Box 32, enter the service facility's name; address (without a comma between the city and state) and a nine-digit ZIP code (without a hyphen); and telephone number. This information is not required when clinical laboratories bill for their own services.

Providers can enter the facility's NPI in Box 32A. In Box 32B, enter the Medi-Cal provider number of the facility where the services were rendered if the Place of Service on the claim is other than Office (11), Home (12), Ambulance (Land) (41), Ambulance (Air or Water) (42), Residential Substance Abuse Treatment Facility (55), End Stage Renal Disease Treatment Facility (65), Independent Laboratory (81) or Other (99). This information is required for all other Place of Service codes.

Box 33



In Box 33, enter the billing provider's name; address (without a comma between the city and state) and nine-digit ZIP code (without a hyphen); and telephone number.

Providers can enter the billing provider's NPI in Box 33A. In Box 33B, enter the billing provider's individual or group Medi-Cal provider number.

Fresno Medi-Cal Field Office to Close

The Fresno Medi-Cal Field Office (FMCFO), located at 3374 East Shields Avenue, Suite C-4 in Fresno, California, will close no earlier than November 2007.

The closure is part of a statewide effort to streamline Medi-Cal field office operations and to increase consistency in *Treatment Authorization Request* (TAR) decisions on behalf of Medi-Cal recipients.

Note: The closure of other Medi-Cal field offices is not being considered, and the Medical Case Management (MCM) program will not be closing.

The majority of TAR services currently handled by the Fresno Field Office staff will be redirected to other Medi-Cal field offices. Hospital onsite review of TARs at area hospitals will continue, as will local MCM activities.

Provider notification regarding specific details on the redirection of the various TAR types adjudicated by the FMCFO to other Medi-Cal field offices will be provided in future *Medi-Cal Updates* as information becomes available. The California Department of Health Services (CDHS) does not anticipate any negative impact to providers or recipients as a result of the closure of the FMCFO, as all TAR and MCM services will continue.

End-Date Non-Specific Diagnosis Codes V72.5 and V72.6

Effective for dates of service on or after March 1, 2007, providers may not submit the following non-specific diagnosis codes when billing for radiology or laboratory procedures:

ICD-9-CM Code	Description
V72.5	Radiological examination, not elsewhere classified
V72.6	Laboratory examination

This information is reflected on manual replacement pages path bil 1 (Part 2) and radi 1 and 2 (Part 2).

Reimbursement Restrictions for E&M Physician Visit Codes

Effective for dates of service on or after March 1, 2007, when any of the following procedure codes have been reimbursed within a previous period of three years to the same provider, for the same recipient, any new patient office visit or home visit codes billed by the provider will be reduced to the reimbursement rate of the corresponding, established visit procedure codes.

CPT-4 Code Range	Description
99211 – 99215	Established patient; office or other outpatient visit
99221 – 99223	New or established patient; initial hospital care
99231 – 99233	subsequent hospital care
99241 – 99245	office consultation
99251 – 99255	initial inpatient consultation
99347 – 99350	Established patient; home visit
99354 – 99357	Prolonged physician service with direct (face to face) patient contact

These restrictions do not apply to California Children's Services (CCS) or the Genetically Handicapped Persons Program (GHPP).

This information is reflected on manual replacement page eval 8 (Part 2).

Newborn and Prenatal Screening Tests Rate Increase

Effective January 1, 2007, the rates for HCPCS codes S3620 and S3625 increased.

Newborn Metabolic Screening Panel
Effective retroactively for dates of service from August 1, 2006 through December 31, 2006, the rate for S3620 (newborn metabolic screening panel, includes test kit, postage and the laboratory tests specified by the state for inclusion in this panel [e.g., galactose; hemoglobin electrophoresis; hydroxyprogesterone, 17-d; phenylalanine (PKU); and thyroxine, total]) was $95.75. For dates of service on or after January 1, 2007, the rate is $102.75. Providers that may have been underpaid will need to promptly resubmit their claims for S3620 to ensure timeliness of payment.

Maternal Serum Triple Marker Screen

For dates of service on or after January 1, 2007, the rate for S3625 (maternal serum triple marker screen including alpha-fetoprotein [AFP], estriol, and human chorionic gonadotropin [HCG]) is $162.00.

This information is reflected on manual replacement page gene ex 3 (Part 2).

Cyanocobalamin Policy Effective Date Correction

An article published in the December 2006 *Medi-Cal Update* erroneously stated that the effective date of the diagnostic restriction policy for CPT-4 code 82607 (cyanocobalamin [vitamin B-12]) was January 1, 2007. This policy became effective June 1, 2003 and was published in the May 2003 *Medi-Cal Update*.

Code 82607 is reimbursable only when billed in conjunction with one or more of the following ICD-9-CM codes. Reimbursement is restricted to three tests per year for the same recipient by the same provider, unless medical justification is entered in the *Remarks* area/*Reserved for Local Use* field (Box 19) of the claim or submitted as an attachment.

Additionally, three of the ICD-9-CM codes have been updated to reflect the highest level of specificity currently available, according to the *International Classification of Diseases – 9th Revision – Clinical Modification (ICD-9-CM)* code book:

ICD-9-CM Code	Description
289.81 – 289.89	Other specified diseases of blood and blood-forming organs
294.10 – 294.11	Dementia in conditions classified elsewhere
780.71 – 780.79	Malaise and fatigue

A future *Medi-Cal Update* will instruct providers how to resubmit previously denied claims for reprocessing.

This information is reflected on manual replacement page path chem 3 (Part 2).

California Children's Services Service Code Groupings Updates

Effective January 1, 2007, updates were made to California Children's Services (CCS) Service Code Groupings (SCGs) 01, 02, 03 and 07.

HCPCS codes X7582, X7588 and X7634 and CPT-4 code 90634 have been end-dated for dates of service on or after January 1, 2007.

In addition, HCPCS codes J9001, J9045 and J9310 and CPT-4 codes 20600, 20605, 20610, 20650, 20670, 20680, 20690, 20692 – 20694, 90384 – 90386, 90399, 90649, 90660, 90680, 90710, 90714 – 90715, 90734, 90740 and 90747 have been added for dates of service on or after January 1, 2007.

Reminder: SCG 02 includes all the codes in SCG 01 plus additional codes applicable only to SCG 02; SCG 03 includes all the codes in SCG 01 and SCG 02 plus additional codes applicable only to SCG 03; and SCG 07 includes all the codes in SCG 01 plus additional codes applicable only to SCG 07. These same "rules" apply to end-dated codes.

The updated information is reflected on manual replacement pages cal child ser 1, 3, 11 and 18 (Part 2).

Family PACT Clinic Dispensed Drugs and Contraceptive Drugs and Supplies Update

Pursuant to *Welfare and Institutions Code* (W&I Code), Section 14132.01, as amended by AB 77, of the Statutes of 2005, the Family PACT (Planning, Access, Care and Treatment) program is implementing fees for onsite dispensing of drugs and supplies.

Effective February 16, 2007, Clinic Dispensing Fees (CDF) for the Family PACT program are implemented for the following HCPCS Level III interim codes. These codes may be used by all Family PACT providers.

HCPCS Code	Description
X7706	(oral contraceptives)
X7716	(azithromycin 250mg tablets)
X7722	(emergency contraception)
X7728	(contraceptive patch)
X7730	(contraceptive vaginal ring)

For the codes listed above, the CDF is defined as the difference between the drug acquisition cost and the rate listed in the Medi-Cal Basic Rate table. The amount listed in the Medi-Cal Basic Rate table shall represent the Family PACT Fixed Claim Rate, which includes the CDF. This Fixed Claim Rate is multiplied by the number of units dispensed and the total is entered in the appropriate box on the claim form. This calculation method is not a change from current policy. However, the recognition of inclusion of the CDF as part of this Fixed Claim Rate is the published policy change.

Providers who choose not to claim a dispensing fee shall continue to claim only the actual acquisition cost of the drug. Reimbursement shall be the lesser of the amount billed or the Medi-Cal limit.

There is no CDF for antibiotic or contraceptive injections, intrauterine contraceptives or contraceptive implants. Policies regarding claims submission for these items remain unchanged.

HCPCS Code X7706 (Oral Contraceptives) Updated Dispensing Limits
Refills are permitted after 14 days for each cycle dispensed (for example: 1 pack refill after 14 days; 3 packs refill after 42 days; and 13 packs refill after 182 days). The existing policy of a maximum quantity of 13 cycles dispensed per client, per provider remains. This policy change allows for the option of continuous use regimen.

Please see **Family PACT**, *page 6*

Family PACT Formulary Additions
Effective for dates of service on or after February 16, 2007, the following drugs and contraceptive supplies are added to the Family PACT formulary for clinic and pharmacy dispensing:

- Ciprofloxacin XR 500 mg
- Miconazole 4 percent vaginal cream
- Clindamycin vaginal ovules 100 mg
- Nonoxynol-9 contraceptive sponge

HCPCS Codes Z7610 and X1500
Effective for dates of service on or after May 1, 2007, the following Family PACT policy updates apply to HCPCS codes Z7610 (miscellaneous drugs for non-surgical procedures) and X1500 (contraceptive supplies). The California Department of Health Services (CDHS), Maternal, Child and Adolescent Health/Office of Family Planning (MCAH/OFP) Branch, has developed a Family PACT Fixed Rate and quantity limit for each medication billed using code Z7610 and a Family PACT Fixed Rate and unit definition for each item billed with code X1500. This information follows in the Family PACT Price Guide.

Z7610
This code may only be used by community clinics, hospital outpatient departments, emergency rooms and surgical clinics.

Code Z7610 includes estradiol, most oral antibiotics, anti-virals and anti-fungals contained in the Family PACT formulary for clinic dispensing. Drugs billed with code Z7610 have no individual rates listed in the Medi-Cal Basic Rate table.

The overall rates in the Family PACT Price Guide are generally comparable to the net cost of the drug or supply to the Medi-Cal program. The methodology used to determine Family PACT Fixed Rates is available upon written request to the MCAH/OFP. Quantity limits for each drug are based on regimens previously defined in the Family PACT Program "2006 Provisional Clinical Services Benefits Grid," published in the June 2006 *Medi-Cal Update*.

CDFs for Z7610 apply once per drug, per claim. CDFs for medications billed with code Z7610 are defined as follows:

- Level A: pharmacist pre-packaged containers of tablets or capsules (flat rate); $3.00 per drug
- Level B: manufacturer pre-packaged tubes or other containers (flat rate); $2.00 per drug

For each Z7610 claim, providers must enter the following in the *Remarks* field (Box 84) on the *UB-92 Claim Form*:

- Name of the drug
- Dosage size
- Number of units dispensed multiplied by the FAMILY PACT Fixed Rate (the subtotal)
- CDF (if claimed)

Providers must then calculate a total and enter it in the *Total Charges* field (Box 47) for the appropriate line.

Please see **Family PACT**, *page 7*

The following table provides examples for completing a claim form for clinic dispensed drugs.

Remarks* field (Box 84) of the *UB-92 Claim Form				**Box 46**	**Box 47**
Drug Name	**Dosage size**	**Number of units dispensed multiplied by fixed claim rate (subtotal)**	**Plus CDF**	**Total Charges**	**"Service Units"**
Acyclovir	200 mg capsule	50 capsules X $0.15/capsule = $7.50	$ 3.00	$ 10.50	1
Butoconazole	2% SR cream/tube	1 tube X $29.33/tube = $29.33	2.00	31.33	1
Doxycycline Probenecid	100 mg tablets 500 mg tablets	28 tablets X $0.14 = $3.92 2 tablets X $0.71 = $1.42	3.00 3.00	11.34	1

Every Z7610 claim must have an acceptable secondary diagnosis code entered on the *UB-92 Claim Form* for reimbursement. Only one secondary diagnosis code can be processed per claim form.

When the same secondary diagnosis code applies to more than one Z7610 drug claimed, more than one regimen may be listed in the *Remarks* field (Box 84) of the claim form. If a combination of drug regimens is claimed under a single secondary diagnosis code, it should be entered as one (service) unit. If two or more drugs are dispensed with different secondary diagnoses, then a separate claim form must be submitted for each secondary diagnosis and its corresponding drug(s). If the *Remarks* area is left blank, the claim will be denied.

X1500

Contraceptive supplies that may be billed by all Family PACT providers with code X1500 include the following: male or female condoms, spermicides, lubricants, diaphragms, cervical caps and basal temperature thermometers. These supplies are dispensed alone or in combination and are currently subject only to a maximum Medi-Cal basic rate, which is currently $14.99.

The overall rates are generally comparable to the net cost of the drug or supply to the Medi-Cal program. The methodology used to determine Family PACT Fixed Rates is available upon written request from the OFP.

The CDF for contraceptive supplies claimed under code X1500 is defined as follows:

- Level C: Contraceptive Supplies, ten percent of contraceptive supply claim (rounded to the nearest cent)

The combined total of all supplies plus CDF cannot exceed the Medi-Cal basic rate for code X1500.

To avoid denials on claims, providers billing for code X1500 must enter the following in the *Reserved for Local Use* field (Box 19)/*Remarks* field (Box 84) of the claim form: the quantity of condoms, film, suppositories, contraceptive sponges, diaphragms, cervical caps or grams of spermicide/lubricant dispensed.

Multiply the number of each product by the fixed claim rate for each product and add a dispensing fee equal to ten percent of the sum for individual products to calculate the total amount claimed for code X1500. The total is entered in the *Charges* field (Box 24F)/*Total Charges* field (Box 47) of the claim form and shall not exceed the Medi-Cal limit.

The following table provides examples for completing a claim form for clinic dispensed drugs.

Remarks* field (Box 84) of the *UB-92 Claim Form ***Reserved for Local Use* field (Box 19) of the *HCFA 1500* claim form**				**Box 47/ Box 24F**	**Box 46/ Box 24G**
Supply Name	**Unit**	**Number of units dispensed multiplied by fixed claim rate (subtotal)**	**Plus 10% CDF**	**Claim total**	**"Units" on claim**
Male condoms	1 condom	35 condoms X $0.28/condom = $9.80	$ 0.98	$ 10.78	1
Spermicidal foam	1.4 oz. can	1 can (40 grams) X $0.21/gram = $8.40	0.84	9.24	1

Please see **Family PACT**, *page 8*

The following tables, "Family PACT Price Guide," are the dispensing guidelines for covered drugs, dosage size/billing unit, maximum billing units per claim, the Family PACT rate per unit, the maximum drug cost, the clinic dispensing fee, the upper payment limit and the fill frequency (days). The Family PACT Price Guide will be updated periodically and will be posted on the Family PACT Web site at **www.familypact.org**.

Medication	Dosage Size/ Billing Unit	Maximum Billing Units per Claim	Family PACT Rate per Unit	Maximum Drug Cost	Clinic Dispensing Fee	Upper Payment Limit	Fill Frequency (days)
Acyclovir	200 mg caps	50	$ 0.15	$ 7.50	$ 3.00	$ 10.50	30
Acyclovir	400 mg tabs	30	0.23	6.90	3.00	9.90	30
Acyclovir	400 mg tabs	60	0.23	13.80	3.00	16.80	30
Acyclovir	800 mg tabs	10	0.47	4.70	3.00	7.70	30
Azithromycin	1 g packet	1	17.18	17.18	2.00	19.18	7
Azithromycin	1 g packet	2	17.18	34.36	2.00	36.36	7
Azithromycin	500 mg tabs	4	10.64	42.56	3.00	45.56	7
Butoconazole	2% tube	1	29.33	29.33	2.00	31.33	30
Cefpodoxime	200 mg tabs	2	3.83	7.66	3.00	10.66	7
Cephalexin	250 mg caps	40	0.18	7.20	3.00	10.20	7
Cephalexin	500 mg caps	20	0.36	7.20	3.00	10.20	7
Ciprofloxacin	250 mg tabs	2	0.38	0.76	3.00	3.76	7
Ciprofloxacin	250 mg tabs	6	0.38	2.28	3.00	5.28	7
Ciprofloxacin	500 mg tabs	6	0.45	2.70	3.00	5.70	7
Ciprofloxacin	500 mg tabs	1	0.45	0.45	3.00	3.45	7
Ciprofloxacin XR	500 mg tabs	3	5.82	17.46	3.00	20.46	7
Clindamycin	150 mg caps	28	0.92	25.76	3.00	28.76	30
Clindamycin	100 mg ovules/3pk	1	29.70	29.70	2.00	31.70	30
Clindamycin	2% tube	1	35.86	35.86	2.00	37.86	30
Clindamycin SR	2% tube	1	52.50	52.50	2.00	54.50	30
Clotrimazole	1% tube	1	6.82	6.82	2.00	8.82	30
Clotrimazole	2% tube	1	7.16	7.16	2.00	9.16	30
Clotrimazole	100 mg pack	1	6.21	6.21	2.00	8.21	30
Clotrimazole	200 mg pack	1	7.57	7.57	2.00	9.57	30
Doxycycline	100 mg caps/tabs	28	0.14	3.92	3.00	6.92	30
Doxycycline	100 mg caps/tabs	56	0.14	7.84	3.00	10.84	30
Doxycycline	100 mg caps/tabs	14	0.14	1.96	3.00	4.96	7

Please see **Family PACT**, *page 9*

Medication	Dosage Size/ Billing Unit	Maximum Billing Units per Claim	Family PACT Rate per Unit	Maximum Drug Cost	Clinic Dispensing Fee	Upper Payment Limit	Fill Frequency (days)
Estradiol	0.5 mg tabs	30	0.18	5.40	3.00	8.40	30
Estradiol	1 mg tabs	30	0.22	6.60	3.00	9.60	30
Estradiol	2 mg tabs	30	0.31	9.30	3.00	12.30	30
Fluconazole	150 mg tab	1	9.65	9.65	2.00	11.65	30
Imiquimod	5% pack	1	124.73	124.73	2.00	126.73	30
Metronidazole Gel	0.75% tube	1	$ 35.04	$ 35.04	$ 2.00	$ 37.04	30
Metronidazole	250 mg tabs	56	0.08	4.48	3.00	7.48	30
Metronidazole	250 mg tabs	28	0.08	2.24	3.00	5.24	7
Metronidazole	500 mg tabs	4	0.22	0.88	3.00	3.88	7
Metronidazole	500 mg tabs	28	0.22	6.16	3.00	9.16	30
Metronidazole	500 mg tabs	14	0.22	3.08	3.00	6.08	7
Miconazole	100 mg pack	1	6.75	6.75	2.00	8.75	30
Miconazole	200 mg pack	1	13.77	13.77	2.00	15.77	30
Miconazole	2% tube	1	7.17	7.17	2.00	9.17	30
Miconazole	4% tube	1	7.30	7.30	2.00	9.30	30
Miconazole	200 mg 2% pack	1	8.94	8.94	2.00	10.94	30
Nitrofurantoin SR	100 mg caps	20	1.51	30.20	3.00	33.20	30
Nitrofurantoin	100 mg caps	40	1.28	51.20	3.00	54.20	30
Ofloxacin* (PID only)	200 mg tabs	56	2.17	121.52	3.00	124.52	30
Ofloxacin* (PID only)	400 mg tabs	28	4.35	121.80	3.00	124.80	30
Podofilox	0.50% pack	1	76.88	76.88	2.00	78.88	30
Probenecid	500 mg tabs	2	0.71	1.42	3.00	4.42	30
SMX/TMP	400-80 mg tabs	28	0.12	3.36	3.00	6.36	7
SMX/TMP	800-160 mg tabs	14	0.15	2.10	3.00	5.10	7
Terconazole	0.40% tube	1	43.43	43.43	2.00	45.43	30
Terconazole	0.80% tube	1	39.74	39.74	2.00	41.74	30
Terconazole	80 mg pack	1	34.05	34.05	3.00	37.05	30
Tinidazole	250 mg tabs	8	1.38	11.04	3.00	14.04	7
Tinidazole	500 mg tabs	4	2.76	11.04	3.00	14.04	7

***** Ofloxacin tablets are only payable when secondary ICD-9-CM diagnosis codes 614.0, 614.2 or 615.0 are included in the other diagnosis *Code* field (Box 68) of the *UB-92 Claim Form*.

Please see **Family PACT**, *page 10*

Contraceptive Supplies	Unit	Reimbursement Per Unit
Male Condoms	each	$ 0.28
Female Condoms	each	2.76
Spermicidal Suppositories	each	0.53
Spermicidal Film	each	0.69
Spermicidal Gel/Jelly/Cream/Foam	gram	0.21
Lubricant (non-spermicidal)	gram	0.03
Nonoxynol 9 Contraceptive Sponge	each	2.35
Basal Body Thermometer	each	5.53

Providers who choose not to claim a dispensing fee should continue to claim only the actual acquisition cost of the drug. Reimbursement is the lesser of the amount billed or the Medi-Cal upper payment limit.

Revised *Family PACT Policies, Procedures and Billing Instructions* (PPBI) manual pages will be issued in a future mailing to Family PACT providers. For more information about Family PACT, call the Telephone Service Center (TSC) at 1-800-541-5555 from 8 a.m. to 5 p.m. Monday through Friday, except holidays, or visit the Family PACT Web site at **www.familypact.org**.

Provider Orientation and Update Sessions

Medi-Cal providers seeking enrollment in the Family PACT (Planning, Access, Care and Treatment) Program are required to attend a Provider Orientation and Update Session. The dates for upcoming sessions are listed below.

Individual and group providers wishing to enroll must send a physician-owner to the session. Clinics wishing to enroll must send the medical director or clinician responsible for oversight of medical services rendered under the Medi-Cal provider number.

Office staff members, such as clinic managers, billing supervisors and patient eligibility enrollment supervisors, are encouraged to attend but are not eligible to receive a *Certificate of Attendance*. Currently enrolled clinicians and staff are encouraged to attend to remain current with program policies and services. Medi-Cal laboratory and pharmacy providers are automatically eligible to participate in the Family PACT Program without attending an orientation session.

The session covers Family PACT provider enrollment and responsibilities, client eligibility and enrollment, special scope of client services and benefits, provider resources and client education materials. This is not a billing seminar.

Please note the upcoming Provider Orientation and Update Sessions below.

San Bernardino
April 12, 2007
8:30 a.m. – 4:30 p.m.
Clarion Hotel & Convention Center
295 North E Street
San Bernardino, CA 92401
(909) 381-6181

Oakland
June 7, 2007
8:30 a.m. – 4:30 p.m.
Park Plaza Hotel
150 Hegenberger Road
Oakland, CA 94621
(510) 635-5000

Please see **Family PACT**, *page 11*

For a map and directions to these locations, go to the Family PACT Web site (**www.familypact.org**) and click "Providers" at the top of the home page, then "Provider Training," and finally, click the appropriate location.

Registration
To register for an orientation and update session, go to the Family PACT Web site (**www.familypact.org**) and click "Providers" at the top of the home page, then "Provider Training," and finally, click the "Registration" link next to the appropriate date and location and print a copy of the registration form.

Fill out the form and fax it to the Office of Family Planning, ATTN: Darleen Kinner, at (916) 650-0468. If you do not have Internet access, you may request the registration form by calling 1-877-FAMPACT (1-877-326-7228).

Providers must supply the following when registering:

- Name of the Medi-Cal provider or facility
- Medi-Cal provider number
- Contact telephone number
- Anticipated number of people attending

Check-In
Check-in begins at 8 a.m. All orientation sessions start promptly at 8:30 a.m. and end by 4:30 p.m. At the session, providers must present the following:

- Medi-Cal provider number
- Medical license number
- Photo identification

Note: Individuals representing a clinic or physician group should use the clinic or group Medi-Cal provider number, not an individual provider number or license number.

Certificate of Attendance
Upon completion of the orientation session, each prospective new Family PACT medical provider will receive a *Certificate of Attendance*. Providers should include the original copy of the *Certificate of Attendance* when submitting the Family PACT application and agreement forms (available at the session) to Provider Enrollment Services. Providers arriving late or leaving early will not receive a *Certificate of Attendance*. Currently enrolled Family PACT providers do not receive a certificate.

Contact Information
For more information about the Family PACT Program, please call 1-877-FAMPACT (1-877-326-7228) or visit the Family PACT Web site at **www.familypact.org**.

The Family PACT Program was established in January 1997 to expand access to comprehensive family planning services for low-income California residents.

Medi-Cal List of Contract Drugs

The *Drugs: Contract Drugs List Part 1 – Prescription Drugs* provider manual section has been updated.

Change, effective January 19, 2007

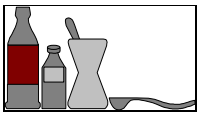
Drug	**Size and/or Strength**	
PRAVASTATIN		
+ Tablets	10 mg	90's
	20 mg	90's
	40 mg	90's
	80 mg	90's
~~(NDC labeler code 00003 [Brystol-Myers Squibb] only.)~~		

Changes, effective February 1, 2007

Drug	**Size and/or Strength**	
ALEMTUZUMAB		
Injection	**~~30 mg/3 cc ampule~~**	
	30 mg/1cc vial	
BETAXOLOL HCL		
Ophthalmic drops	0.25 %	2.5 cc
		5 cc
		10 cc
		15 cc
(NDC labeler code 00065 [Alcon Laboratories, Inc.] for 0.25 % only)		
	0.5 %	2.5 cc
		5 cc
		10 cc
		15 cc
DEXMETHYLPHENIDATE HCL		
* Capsules, extended release	5 mg	
	10 mg	
	15 mg	
	20 mg	

* Restricted to use in Attention Deficit Disorder in individuals between 4 and 16 years of age.
(NDC labeler code 00078 [Novartis Pharmaceutical Corporation] capsules only.)

\+ Frequency of billing requirement



DRUG USE REVIEW
Educational Information

Over Utilization of Migraine Medications in the Medi-Cal FFS Population

Migraine headaches affect more than 29 million people in the United States.[1] It is a debilitating disease, characterized by throbbing head pain, usually located on one side of the head and often accompanied by nausea and sensitivity to light and/or sound.[2] The pain is disabling for patients, making it difficult for them to work or perform daily activities. A World Health Organization (WHO) survey rated migraines as one of the most disabling chronic disorders.[2]

The average age of onset of migraines is during adolescence and most migraines commonly occur between 15 and 55 years of age.[1] Women are three times more likely than men to have migraine attacks.

Migraine attacks occur periodically and can last from four to 72 hours.[2] Symptoms vary by episode and individual. This can make it difficult for patients to determine if and when to take abortive migraine medications. There are currently seven medications on the market classified as triptans to use as abortive therapy. There are also ergotamine and narcotic pain medications that can be used for acute migraine treatment (typically in combination with abortive therapy). Included with pharmacologic therapy, there are non-pharmacologic measures that can be utilized to help prevent a migraine attack. These include education about the disorder, how migraines occur and changes in lifestyle.[2]

Patients with any one of the following symptoms should be considered for preventative therapy for migraines:[3,4]

- Two attacks per month, with disability totaling three or more days. If the pain severity is high, then less than two attacks per month should be considered for preventative therapy
- If migraine interferes with normal daily activity
- Use of abortive migraine medications greater than two times per week[5]
- Abortive medications contraindicated, ineffective or not tolerated

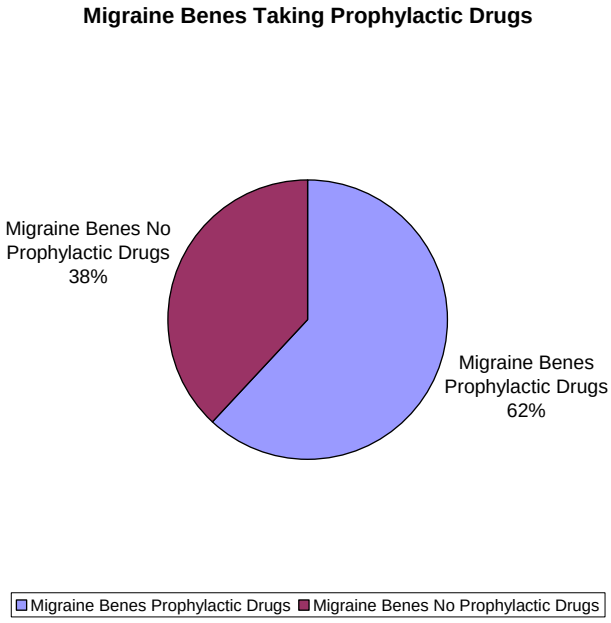
Over utilization of abortive and other acute migraine medications should be discouraged by medical professionals. Patients should be educated on possible consequences when abortive medications are overused, and that rebound migraines can occur. Preventative therapy can assist in decreasing the overall rate of migraine occurrences and decrease the number of emergency room visits for migraine.

Payments to pharmacies in the Medi-Cal fee-for-service (FFS) program for abortive anti-migraine drug therapy, triptans and ergotamine, for the period of October 1, 2005 through September 30, 2006 totaled $6.2 million. Usage of triptans accounted for $5.7 million of that total.

Please see **Over Utilization**, *page 14*

A retrospective study of Medi-Cal FFS beneficiaries (excluding Medicare beneficiaries) with migraines was conducted to determine if patients are over utilizing migraine medications, using preventative medications to control migraine attacks and whether they are frequently using hospital emergency rooms when seeking treatment for their migraines. Patients who were Medi-Cal FFS in 11 out of 12 months during the period of October 2005 through September 2006, and who had two or more paid claims for migraine medications were considered for the study.

- Using decision support software (Identification of Migraine Prevention and Acute Therapy, or IMPACT, developed by Ortho-McNeil Neurologics), 5,787 Medi-Cal beneficiaries met the criteria.
  - 84 percent of beneficiaries using triptans were female (4,879 out of 5,787). American Migraine Prevalence and Prevention Study (AMPP) data showed 77 percent of participants being female.
  - 47 percent of beneficiaries with migraines were between 46 and 64 years of age.
  - 59 percent of beneficiaries would be considered "high utilizers" due to their use of three or more doses per month of a triptan. This is based on current California Department of Health Services (CDHS) policy of three dispensings of a triptan prescription for tablets/nasal spray or 10 dispensings of the injectable kit in a 12-month time period. Anything beyond this would be considered a "high utilizer" and would require a *Treatment Authorization Request* (TAR) for payment.
- Further analysis determined that 62 percent of beneficiaries taking migraine medication were also taking some sort of preventative (prophylactic) medication. There are four categories of preventative medication that are commonly used, but only a small number are FDA approved to help prevent migraines. Information on whether these patients are taking the preventative medications for true prevention or just taking it due to a co-morbid disease state is not known. However, even if not taken specifically for prevention, the outcome of decreased migraine occurrences should still occur.



Please see **Over Utilization**, *page 15*

Additionally, of the 7,978 Medi-Cal FFS beneficiaries that had at least one claim for a triptan or an ergotamine in this same time frame, 9 percent had been seen in the emergency room with a diagnosis of migraine. These patients may not be getting satisfactory relief and/or prevention of their migraine episodes, and would be ideal candidates for initiation of or adjustment to their preventative therapy.

Recommendations

Medi-Cal wants to make certain that beneficiaries that suffer from migraines can get both the acute treatment needed and the preventative therapy that may be warranted. The following steps should be followed by all providers:

- Prescribers should monitor how frequently their patients are experiencing migraines through both consultation with the patient regarding the use of medications and use of patient migraine journals.
- Pharmacists should consult beneficiaries regarding the consequences of over utilization of abortive migraine medication and use of a preventative therapy and should contact the prescriber if over utilization continues without the use of preventative therapy. Pharmacists should also discuss what may be triggering a migraine and how to avoid those triggers.
- For all providers, follow the guidelines on when to initiate preventative therapy for migraine sufferers.

References

1. Lipton R.B. et al, Migraine Prevention Patterns in a Community Sample: Results from the American Migraine Prevalence and Prevention (AMPP) Study. Poster presented at the 2005 annual meeting of the American Headache Society & AMPP Study Fact Sheet.
2. Goadsby P.J., Lipton R.B., Ferrari M.D. Migraine – Current Understanding and Treatment. *N Engl J Med* 2002; 346:257-270.
3. Snow V et al, for the American Academy of Family Physicians and the American College of Physicians – American Society of Internal Medicine. *Ann Intern Med*. 2002; 137:840-849.
4. Ramadan NM et al, and the US Headache Consortium. 2000:1-55.
5. Silberstein S, Practice Parameter: Evidence-Based Guidelines for Migraine Headache (an evidence-based review): Report of the Quality Standards Subcommittee of the American Academy of Neurology. *Neurology* 2000; 55:754-762.

Instructions for Manual Replacement Pages — Part 2

February 2007

Obstetrics Bulletin 391

Remove and replace:	cal child ser 1 thru 24 eval 7 thru 10 gene 3 thru 6 * gene ex 3
Remove and replace at the end of the *HCFA 1500 Completion* section:	*Code Correlation Guide* 1/2 *
Remove and replace:	path bil 1/2 path chem 3/4 radi 1/2 rates max 7/8 * tar field 9/10 *

DRUG USE REVIEW (DUR) MANUAL

Remove from the *Education* section:	36-33
Insert:	36-33 thru 36

* Pages updated due to ongoing provider manual revisions.